

The National Integrated Prevention of Mother-To-Child Transmission (PMTCT) of HIV Accelerated Plan at a Glance



health

Department:
Health
REPUBLIC OF SOUTH AFRICA



A. Background

Just over one million babies are born in South Africa every year. An estimated 300,000 of these babies are born exposed to HIV, based on the HIV prevalence rate of 29% in 2007 among pregnant women. Without access to a programme to prevent mother-to-child transmission of HIV, around 90,000 (approximately 30%) of these babies will be born HIV infected every year. However, a comprehensive PMTCT intervention has the capacity to reduce the neonatal infection rate to less than 5%, thus saving 75,000 baby lives annually.

Besides reducing infant mortality in the context of a generalized HIV epidemic a PMTCT programme also provides an entry point for strengthening health systems to improve maternal and child health outcomes. Successfully implemented, a national PMTCT programme will assist South Africa to meet the health-related Millennium Development Goals (MDGs 4, 5 and 6)¹.

A national PMTCT programme was initiated in 2001, using a single dose nevirapine regimen. This was updated in 2008 to employ a dual therapy protocol (AZT and nevirapine). Infant feeding guidelines were also updated according to the latest evidence. Aspects of this programme are currently implemented in all hospitals and over 90% of primary health care facilities across the country. Despite these efforts, the PMTCT programme has not delivered according to expectations and must be strengthened. At present mother-to-child transmission rates vary widely across the country, averaging at 12% nationally, but with some districts reporting MTCT rates of above 20%. This is higher than the transmission rate of <5% expected from a well functioning PMTCT programme and the target in the National Strategic Plan for HIV and AIDS and STIs (NSP) 2007-2011.

This document serves to describe the Accelerated Plan² in brief. For a full description of the Plan, please refer to the longer document as well as the document that contains the best practices³ found in various districts and facilities in the country.

1. MDG 4 calls for a two-thirds reduction in child deaths; MDG 5 calls for a three-quarters reduction in maternal deaths; MDG 6 aims to combat diseases, especially HIV & AIDS and malaria (Time frame, 1990 to 2015).

2. Operational Plan for Accelerating Scale up and Improvement of the Quality of Services for Prevention of Mother to Child Transmission (PMTCT) in the context of Integrated Maternal and Child health care in South Africa (DOH 2009).

3. Source: Best practices in prevention of mother-to-child transmission (PMTCT) of HIV programmes in South Africa, 2009. National Department of Health, Medical Research Council, University of the Western Cape, UNICEF, USAID.

B. The Accelerated Plan (A-Plan)

I. Aim Of The Plan

The PMTCT Accelerated Plan is a focused plan of implementation and is part of the National PMTCT programme Operational Plan. It is based on a bottleneck analysis conducted in a review of the PMTCT programme and aims to fast track strengthening of the PMTCT programme with an initial focus on 18 health districts. The plan aims to be a catalyst in driving the following:

- Scaling up access and improve quality of PMTCT services to reduce MTCT to less than 5% by 2011 as per the National Strategic Plan for HIV,AIDS and STIs (NSP) 2007-2011,
- Integration of PMTCT into the existing maternal and child health interventions such as basic antenatal care, integrated management of childhood illnesses, expanded programme on immunisation and sexual and reproductive health, and to ensure that HIV infected mothers and babies are appropriately referred to HIV and AIDS services for continued treatment, care and support,
- Scaling up efforts to achieve the Millennium Development Goals (MDGs) 4,5 and 6,
- Revitalising the health services to improve health outcomes for mothers and children,
- Accelerating HIV prevention,
- Harnessing and strengthening of efforts, networks and partnerships between government, civil society sectors and organizations, the private sector and the developmental partners towards a multi-sectoral response.

The A-Plan is not a vertical HIV and AIDS programme but an integrated plan that encompasses all components of maternal and child care which tracks the continuum of care from conception, through pregnancy, delivery and care of the neonate. It is not a new programme but does harness the additional resources provided by our development partners to ensure rapid scale up and improved service delivery.

The A-Plan plays a unique role for the PMTCT programme in that its focus is on areas of greatest need and poor performance within the PMTCT programme. Implementation of the plan will, initially, focus on the 18 health districts where the need is greatest. These districts have been identified using a selection of maternal and child health indicators as well as socio-economic indicators that include poverty, unemployment, access to water and sanitation. The aim is to improve programme indicators in these priority districts while continuing to provide services nationally. Lessons learned, as well tool developed for use in the A-Plan will be shared across the country to ensure that all districts benefit – it should be thought of as the leading edge of improvement which as it moves forward also pulls other districts forward.

The other novel aspect of this plan is that it ensures that the efforts of a wide range of technical partners who are working public health professionals and managers at facility level are maximised to ensure that all efforts are done to scale. This drive for scale will ensure that we harness all resources to rapidly improve access and quality of care within the PMTCT programme.

The A-plan will be operational for 24 months, with the goal of embedding improvements in daily practice.



2. Objectives

The thrust of the intervention focuses on expanding access to PMTCT services and increasing demand as well as to improving the quality of these services. The A-Plan has eleven specific objectives, linked to the general objectives of the national PMTCT programme, to improve the outcomes of the PMTCT programme. These are to:

- 2.1 Increase the proportion of early antenatal care bookings (under 20 weeks),
- 2.2 Increase the proportion of pregnant women tested for HIV,
- 2.3 Increase the proportion of HIV-positive women who are tested for CD4 count,
- 2.4 Increase the proportion of HIV-positive women receiving dual ARV prophylaxis,
- 2.5 Increase the proportion of eligible HIV-positive pregnant women initiated on HAART,
- 2.6 Increase the proportion of HIV-exposed infants receiving dual ARV prophylaxis,
- 2.7 Increase the proportion of HIV-exposed infants receiving a PCR test around 6 weeks,
- 2.8 Increase the proportion of HIV-exposed infants initiated on Cotrimoxazole,
- 2.9 Increase the proportion of HIV-positive mothers who receive counselling in infant feeding options,
- 2.10 Decrease the proportion of infants with a positive PCR, among those HIV-exposed infants who are tested,
- 2.11 Increase the proportion of HIV-positive infants who are initiated on HAART and receive continuum of care and support.

3. Key Interventions

The A-Plan has been designed via a wide-ranging consultation process with multilateral, bilateral and technical and civil society partners who have been funding and working in support of our health and PMTCT programmes. It therefore builds on a wealth of research and best practices as reflected in the annex and in the best practice review. The A-Plan is based on a comprehensive analysis of bottlenecks and weaknesses in the implementation of the PMTCT service, and on successful models already tested across the country. It employs a range of tried and tested methods including sustainable quality improvement methodology and accurate data capture and analysis to help health workers improve their own practices. It involves working with the sub-district management team to determine the areas that need strengthening, and designing interventions that the sub-district, with support from technical partners, will address in a focussed manner.

The methodology of the plan is two sided and combines improvements in the quality of clinical services at facility-level to address health system and programmatic (supply side) challenges with social mobilization and mass media interventions (demand side) to encourage positive health seeking behaviour to improve the utilization of PMTCT and allied services. The supply side focuses on addressing bottlenecks in the PMTCT programme as identified in each district whilst 'demand' side addresses issues like HIV prevention, stigma, attitudes, knowledge barriers and behaviour. Strategies to address these issues include community dialogues, advocacy pertaining to male involvement in particular and family and community involvement and training of community workers to facilitate discussions on HIV prevention and PMTCT at health facilities.

4. Project Management Of The A-Plan

Implementation will take place at the district level, based on policy guidance and direction from the Provincial and National Departments of Health. Districts and Provinces will be responsible for monitoring and evaluating their own performance and dissemination of Best Practices on a quarterly basis.

A project management team has been established at the national Department of Health to strengthen the PMTCT programme. The role of this team is to ensure that all partners work together to ensure measurable progress against key indicators that are listed in the section below. At the provincial level, PMTCT managers will support district and sub-district management teams to work with health facilities and communities to strengthen the PMTCT programme.

Technical partners, funded by development agencies, who are already working in a number of health districts have agreed to coordinate their work to achieve the national targets. They will work through provincial departments of health and with district and sub-district management teams. These partners include sectors within the South African National AIDS Council, UNAIDS, UNICEF, UNFPA, CDC, USAID, EU, IHI, RHRU, Population Council, Broadreach, JHHESA, Mindset, CMT, UKZN, URC, ICAP, EGPAF, Right to Care, MRC, ECHO, CRH, ARK, FPD, M2M, the Eastern Cape Regional Training Centre, HISP, John Snow Institute and others.



5. Monitoring And Indicators

The District Health Information System (DHIS) already includes a large number of indicators to monitor the PMTCT programme. A subset of critical indicators has been identified to monitor the Accelerated Plan.

These are:

- Maternal HIV testing rate,
- Maternal CD4 testing rate,
- Maternal ARV prophylaxis uptake,
- Maternal HAART uptake,
- Infant ARV prophylaxis uptake,
- Infant Co-trimoxazole prophylaxis uptake,
- Counseling rate on infant feeding options,
- PCR testing rate,
- Mother-to-child transmission rate,
- HAART uptake rate for HIV-positive infants,
- Early booking (before 20 weeks).

The indicators will be used to measure and monitor the outcomes and impact of the A-Plan. The clinical 'supply' quality improvements and social mobilization strategies in the A-Plan are anchored by the II objectives and will both contribute in improving the outcomes that are measured by these indicators.

6. Resources

While provinces have already budgeted for the provision of PMTCT services, additional resources for the A-Plan have already been secured and will be provided by a range of development partners. Every effort will be made to ensure that all interventions are institutionalized, and are therefore sustainable.



Annexure

Table Of Good Practices In South Africa 3

Key PMTCT focus area	Best Practice Site Province/site/ specific practice	Specific Activity /Activities	Key driver (KD) and Partners
Section I: Creating an enabling environment			
• Creating a positive environment for PMTCT – community engagement	• Ndawana – Edzinkulu - Sisonke district • WC/Mothers to mothers	• Community engagement to address stigma regarding HIV, and to develop a system whereby community workers offer VCT and PCR testing at home	• Edzinkulu (NGO) and the District Health Management Team
• Prioritization of PMTCT	• Gauteng/PMTCT working group	• Creation of a PMTCT working group, and regular meeting of this group to coordinate PMTCT activities within the broader MCH framework, and to address bottlenecks in PMTCT. Group should comprise all stakeholders working on PMTCT in the province	• Gauteng Department of Health
• Developing standardized guidelines/protocol for PMTCT	• Western Cape/provincial process to develop a PMTCT protocol	• Consultation with technical experts and implementers to develop standardized guidelines and protocols for PMTCT implementation	• Western Cape Provincial Department of Health

Key PMTCT focus area	Best Practice Site Province/site/ specific practice	Specific Activity /Activities	Key driver (KD) and Partners
Section 2: Comprehensive approaches to PMTCT improvement			
PMTCT integration into MCH and nutrition services	- Kwa Zulu Natal/ Amajuba district/ Integration - Mpumalanga/South west Tshwane/birth register and BANC - Mpumalanga – MRC/ birth register - Western Cape – IHI/ Infant follow-up and mother-child card	- Reorganization of clinic activities and flow, and task shifting or task sharing to facilitate and integrated PMTCT activities into routine services - Development of a new birth register that includes PMTCT, and postnatal patient-held card that integrates PMTCT and adaptation of the RTHC to facilitate follow –up	- Amajuba District Health Management Team and MRC - Mpumalanga DoH, MRC, IHI
Developing comprehensive HIV care and treatment of mothers and children: Experiences from Limpopo Province	Limpopo/Vhembe/ UL project on comprehensive HIV care for mothers and children	Creation of mentoring teams to improve quality of PMTC care; use of an antenatal register	Limpopo DoH, University of Limpopo Department of Paediatrics and Child Health
Use of data/audit cycle to improve PMTCT services	Kwa Zulu Natal/ 20 000 plus/IHI site Cape Metro District Services and Cape Town City Health IHI supported sites	Use of data to change practices and improve PMTCT implementation	KZN Department of Health, District Health Management Teams, Department of Padiatrics and Child Health, IHI
Comprehensive quality improvement in PMTCT programs	Mpumalanga, KZN, North West, Limpopo, Eastern Cape	Implementation of a comprehensive QI approach including QA training, monthly monitoring and quarterly evaluation (continuous quality improvement cycles) to improve PMTCT implementation	DOH, URC/HCI Project

Key PMTCT focus area	Best Practice Site Province/site/ specific practice	Specific Activity /Activities	Key driver (KD) and Partners
Section 3: Specific interventions addressing one area of the PMTCT cascade			
• HIV testing	• Gauteng/Soweto-PHRU collaboration/ IHI site Cape Metro District Services and Cape Town City Health IHI supported sites	• VCT offered to every pregnant woman who comes through the clinic. Testing is done on the same day and results are available immediately	• District Health Management Team, PHRU
• Key PMTCT focus area	• Best Practice site • Province/site/specific practice	• Specific activity(ies)	• Key driver (KD) and partners
• CD4 cell count	• Kwa Zulu Natal/ Amajuba district	• HIV testing bundled with CD4 cell count and sent off on same day	• Amajuba District Health Management Team and MRC
	• Gauteng/Soweto-PHRU collaboration	• Pregnant woman testing HIV positive have blood drawn and sent for a CD4 count at the same visit. A return date is set for a week's time to collect the results.	• District Health Management Team, PHRU
• Dual prophylaxis for mothers	• Gauteng/Soweto-PHRU collaboration Cape Metro District Services and Cape Town City Health IHI supported sites	• Patient contacted directly or via sms if the CD4 count result is <200 and are fast tracked to come in before return date	• District Health Management Team, PHRU

Key PMTCT focus area	Best Practice Site Province/site/ specific practice	Specific Activity /Activities	Key driver (KD) and Partners
Section 3: Specific interventions addressing one area of the PMTCT cascade (continue)			
Dual prophylaxis for infants	Cape Metro District Services and Cape Town City Health IHI supported sites	- Paediatrics day - a special day for paediatric HAART where HIV+ caregivers of HIV positive children also receive treatment. Paediatric outreach from the tertiary hospital allows paediatric patients to receive HAART at their home. PHC and staff at primary care level are skilled up over time to deliver paediatric HAART' - Mothers day – a special day for HIV pregnant women eligible for HAART held on the paediatric clinic day. Allows natural peer support groups to form and focused attention to be given to pregnant women. Women also observe mothers and children receiving HAART. Mother's are kept at the ARV clinic on Mothers Day until the infants PCR results are available. If the baby is PCR+, mother and baby remain in care on the same day, if the baby is PCR_ the mother is moved to a regular default HAART day for continued treatment	Western Cape DoH and IHI

Key PMTCT focus area	Best Practice Site Province/site/ specific practice	Specific Activity /Activities	Key driver (KD) and Partners
Section 3: Specific interventions addressing one area of the PMTCT cascade (continue)			
6-week PCR testing	Kwa Zulu Natal/ Amajuba district	Onsite re-training of staff on correct coding and decoding in all facilities, providing guidelines on HIV coding. Allocation of lay counselor at the immunization station to screen RTHC for HIV codes and motivate mothers with unknown HIV status to test. Ensure that all babies are seen by professional nurses before immunization for screening purposes.	Amajuba District Health Management Team and MRC
Infant feeding counseling	- Kwa Zulu Natal/ Cato Manor Clinic – antenatal infant feeding counseling - Kwa Zulu Natal/ King Edward Hospital - flash heating breast milk	- A 5-finger approach is used to counsel on infant feeding options. This operationalizes AFASS and assesses the following 5 criteria – disclosure (acceptability), fuel source (feasibility), financial stability (affordability and sustainability) and piped running water (safety) - A facility for flash heating breast milk from HIV positive women in hospital has been set up	Department of Paediatrics and Child Health, UKZN, King Edward VIII hospital and District DoH

Key PMTCT focus area	Best Practice Site Province/site/ specific practice	Specific Activity /Activities	Key driver (KD) and Partners
Section 3: Specific interventions addressing one area of the PMTCT cascade (continue)			
• Infant follow-up	• Gauteng/Mpumalanga /Western Cape use of PMTCT stamps, postnatal card, stapling mother and infant cards together, labour ward checklist • Infant follow-up / mother-infant registers	• A PMTCT stamp is used to document all relevant PMTCT information on the road to health chart • SA postnatal card – which is given to the mother and is a hand-held card is used to document all relevant information regarding antenatal and PMTCT-related care to facilitate follow-up. • The labour ward checklist (PMTCT checklist) is used to ensure that all PMTCT activities have been conducted and that all relevant information is recorded on the infant's Road to Health Chart. • The mother-infant follow-up registers and children with special needs register are intended to optimize follow-up of mothers and infants.	• MRC • IHI • Tshwane sub-district • Mpumalanga province • Western Cape District

